

FOR OFFICE USE ONLY

Web Application

Receipt #

ID #

Issue Date

License #

Rhode Island
Board of Medical Licensure and Discipline

Room 205
Three Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License to Practice

- ☐ Allopathic Medicine ☐
- ☐ Osteopathic Medicine ☐

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Applicant - Print Name (First/MI/Last)

- ☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) ☐
and have attached the CSR application to the last page of this application.

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

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Licensure Requirements

U.S./Canadian Graduates

- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of internship or residency by the Accreditation Council for Graduate Medical Education, Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Foreign Graduates

- Successfully completed a course of study from a medical school located outside the United States which is recognized by the World Health Organization.
- Obtained ECFMG certification.
- Have attained a score satisfactory to a medical school approved by the Liaison Committee on Medical Education on a qualifying examination acceptable to the State Board for Medicine.
- Have satisfactorily completed three (3) years of internship or residency in a training program accredited by the Accreditation Council for Graduate Medical Education.
- Have satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Rules and Regulations

The rules and regulations governing the Practice of Medicine can be obtained at the following web site:

http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD_2961.pdf

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

Medical Licensure <http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm>

Controlled Substances Act <http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm>

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application **and** a separate FCVS application.

FCVS Application Process

To have your "core" credentials verified, you must submit an FCVS application directly to the Federation's national office (Texas). This application must be obtained by contacting the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at:

<http://www.fsmb.org>

This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the Board. Because the verification process is the most time-consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.**

The FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education (including Fifth Pathway)
- Postgraduate Training
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS will forward directly to the Board, a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials. For more information about the FCVS process, or if you need assistance completing the FCVS application, call the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287).

Board Application Process

In addition to the FCVS application and verification process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets during the first week of each month. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review and issuance of a license. So that we can move the process along more quickly, if you are an endorsement candidate, and hold an active, unencumbered license in another state, your applications materials will be presented to the Board and a license may be issued **prior** to our receiving the FCVS application. If we thereafter identify any problems with your FCVS application, your license will be voided. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact Lauren Dixon at (401) 222-7887, or by email at LaurenD@doh.state.ri.us.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to the Board.
5. It is your responsibility to check on the status of your application.

Completing your Board Application

1. Complete the **Board Application** pages (6-12). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of \$437.50 (or \$537.50 if you are applying ☐ for your Controlled Substances Registration (CSR)), payable to "Rhode Island General Treasurer" and staple it to ☐ the upper left-hand corner of the first page of the application. These application fees are NON-REFUNDABLE. If ☐ you are applying for your CSR, you **MUST** submit the Board application at the **SAME TIME** as the CSR application. ☐

☐ NOTE: These are Board Application Fees. The FCVS verification fee is an additional and separate fee paid directly ☐ to the FCVS.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 16). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

**Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097**

Physician-Initiated Requests

In addition to the materials you mail to the Board, you must also mail information to other sources for verification. Follow these additional steps as described below:

1. Obtain licensure verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail the **Reciprocity Release Form** (page 17) to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
2. Be certain to sign and complete the identifying information on each form. **The Board must receive the verification(s) directly from the licensing authority.** Make copies of the form as needed. You may obtain

INSTRUCTIONS (continued)

the mailing address of all 69 U.S. medical and osteopathic licensing authorities at the Federation of State Medical Boards' web site at <http://www.fsmb.org> or by calling the Board in question. Please do not contact the Rhode Island Medical Board for mailing addresses of licensing authorities.

3. Submit a "self-query" of the National Practitioner Data Bank (NPDB). The application is a **Practitioner Request for Information Disclosure**, which can be obtained by calling the NPDB, or downloading it from the NPDB web site.

Phone Number for NPDB Information:
NPDB web site:

1-800-767-6732
<http://www.npdb-hipdb.com>

You must mail this completed form directly to NPDB. **When you receive a response, send the Board the ORIGINAL, UNOPENED response.** The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

4. Obtain a total of four **(4) references** attesting to your character and professional abilities. To obtain this verification, mail the enclosed **Reference Form** to each the following:
 - Chief of Staff in the hospital where you currently hold staff privileges;
 - Hospital Administrator in the hospital where you currently hold staff privileges;
 - Two (2) additional practicing physicians.

If you **do not** currently hold staff privileges, mail the **Reference Form** (page 18) to each the following:

- Chairman of the department where you had your major training;
- Director of Residency or Fellowship Training Program;
- Two (2) additional practicing physicians.

Letters or other forms submitted in lieu of the Reference Form will not be accepted. **The Board must receive these forms directly from the reference source.** Make copies of the form as needed.

5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.
6. In order to dispense, prescribe, store, or order controlled substances, you must obtain a **Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.**

The Rhode Island CSR Application is available on page 19. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: ☐

DEA Phone Number (617) 557-2200.

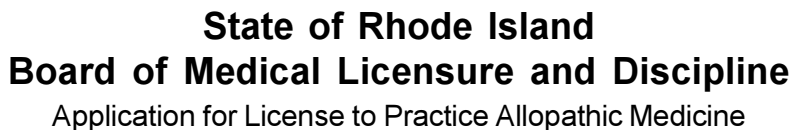
Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

The application process is not considered complete until your Board application, applicable forms and FCVS Physician Information Profile are received in a manner satisfactory to the Board. Neither the Board nor FCVS will accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following the Board meeting for your wallet size license card to be mailed to you. [NOTE: You may **not** practice medicine in Rhode Island until you have received a license number.]

Special Notice about Malpractice Information

In Section 17, "**Malpractice**":

Pursuant to R.I.G.L. § 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past 10 years. The Board will **not** make actual settlement or verdict amounts available to the public. It must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.



1. Name(s)

First Name			
Middle Name			
Surname, (Last Name)			
Suffix (i.e., Jr., Sr., II, III)			Degree (MD, DO)
Maiden, if applicable			
Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).			

Please refer to "Mandatory Addendum to License Application" ☐ on the last page of this application

☐ Male ☐ Female

Month		Day		Year		City and State; OR Province and Country, etc., if NOT U.S.																															

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1st Line Address (Apartment/Suite/Room Number, etc.)

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Second Line Address (Number and Street)

--	--	--	--	--	--

City

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Country, If NOT U.S.

--	--	--	--	--	--	--	--

Home Phone

--	--

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

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[illegible]

11. Medical Licensure

List all states or countries in which you are now, or ever have been licensed to practice medicine or any other profession.



State/Country:

_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive

State/Country:

_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive

DOCUMENTATION: Send a Reciprocity Release Form to each entity. (See page 17)

12. Board Discipline

List any final disciplinary actions by licensing boards in other states.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

☐ Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action
(e.g. TX - Professional Misconduct):

	Month	Year	Type of Discipline:
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____

13. Hospital Privileges

List the name and address of **all** hospitals where you have ever held any type of privileges (e.g., courtesy, admitting, etc.).

NOTE:
This section is continued on the next page.

<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	Type of Privileges
Month	Year		Month	Year	
<input type="text"/>					
Name of Hospital					
<input type="text"/>				<input type="text"/>	<input type="text"/>
City				State	Zip/Postal Code
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	Type of Privileges
Month	Year		Month	Year	
<input type="text"/>					
Name of Hospital					
<input type="text"/>				<input type="text"/>	<input type="text"/>
City				State	Zip/Postal Code
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	Type of Privileges
Month	Year		Month	Year	
<input type="text"/>					
Name of Hospital					
<input type="text"/>				<input type="text"/>	<input type="text"/>
City				State	Zip/Postal Code
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	Type of Privileges
Month	Year		Month	Year	
<input type="text"/>					
Name of Hospital					
<input type="text"/>				<input type="text"/>	<input type="text"/>
City				State	Zip/Postal Code

15. Malpractice

Report all medical malpractice court judgments, medical malpractice arbitration awards and settlements in which payment was awarded or made to a complaining party since September 1, 1988 in any state in which you have held an active license since September 1, 1988. Be certain to read and initial the statement at the bottom of the section.

If necessary, you may continue on a separate 8½ x 11

Month	Day	Year
-------	-----	------

Month

Day

Year

Amount Paid

Basis for Complaint

Month	Day	Year
-------	-----	------

Month

Day

Year

Amount Paid

Basis for Complaint

Month	Day	Year
-------	-----	------

Month

Day

Year

Amount Paid

Basis for Complaint

Month	Day	Year
-------	-----	------

Month

Day

Year

Amount Paid

Basis for Complaint

Month	Day	Year
-------	-----	------

Month

Day

Year

Amount Paid

Basis for Complaint

_____ I certify that I have read and understand the information provided on page 5 "Special Notice about Malpractice Information."
Initials

16. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea ☐ bargain to any federal, state or local statute, regulation, or ordinance or are there any ☐ formal charges pending?

☐ Yes ☐ No

Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

Month	Year

¹For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

17. Questions

Check either Yes or No for each question.

If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.

1. During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ Yes ☐ No

2. During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? ☐ Yes ☐ No

3. During any postgraduate training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ Yes ☐ No

4. During any postgraduate training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? ☐ Yes ☐ No

5. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☐ No

6. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? ☐ Yes ☐ No

7. Have you ever had any disciplinary action(s) taken, or is any pending, against your: License to practice medicine, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state? ☐ Yes ☐ No

8. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? ☐ Yes ☐ No

9. Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? ☐ Yes ☐ No

Note: If you answered "yes" to any of these questions, you must attach a typed explanation on a separate sheet of paper.

18. Physician Honors and Peer Reviewed Publications (Optional)

List any information regarding professional or community service awards and/or information regarding publications in peer-reviewed medical literature within the most recent 10 years.

Do **NOT** submit your curriculum vitae to satisfy the requirements of this section.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Awards, Honors:

Publications:

19. Professional and Community Memberships (Optional)

List any professional and community memberships.

Do **NOT** submit your curriculum vitae to satisfy the requirements of this section.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Professional and Community Memberships:

20. Affidavit of Applicant

Complete this section and sign in the presence of a notary public. Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentality's (local, state, federal or foreign) to release to the Rhode Island Board of Medical Licensure and Discipline any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/ surgery in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Medical Licensure and Discipline of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, who is personally known to me or has produced _____ as documentation and did/did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary Seal

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)

21. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport photo, clear, front view, full face without a hat or dark glasses.

Full length photos, black and white or computer-generated photos will not be accepted.



Sign your name on the line provided, partly upon the page and partly upon the photograph, and provide the date it was taken.



**State of Rhode Island and Providence Plantations
Department of Health**

Office of the Director

Message from the Director of Health

Dear Applicant:

The following page contains questions regarding your race and ethnicity. The Department of Health is attempting to promote diversity among health professionals. The Department can measure its success in promoting diversity by identifying gaps in our diversity. Also, it will utilize this information in order to select members for professional regulatory boards at the Department of Health.

Answering these questions is entirely voluntary. Your willingness to provide this information will not affect your licensure in any way. Data will be used only in accordance with Title VI of the Civil Rights Act of 1964.

Rhode Island has a strong interest in promoting diversity among the health professions. Offering culturally competent health care, better serving minority communities, providing role models for minority youth and encouraging minority persons to become health professionals will make our communities healthier and safer.

Please join us in our attempts to attain these worthy goals by answering the questions on the following page.

Sincerely,

Patricia A. Nolan, MD, MPH
Director of Health

VOLUNTARY RACE/ETHNICITY QUESTIONS*

This information is completely voluntary and will NOT affect your Application in any way.



Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

- 1. Ethnicity:** Are you of Hispanic or Latino ethnicity? ☐ Yes ☐ No
- 2. Race:** Please indicate your race below. (Check as many boxes that apply)
- | | | |
|---|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Other (Specify Below) |

Please specify Race, if you answered "other" above ☐

[illegible]

For the purposes of the above questions kindly use the “Federal Minimum Data Collection” explanations listed below:

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

American Indian or Alaskan Native.

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian (new group does not include Pacific Islanders).

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American.

A person having origins in any of the Black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American”.

Native Hawaiian or Other Pacific Islander.

A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

***This information is being collected in accordance with the Department of Health's Policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.**

AMERICAN BOARD OF MEDICAL SPECIALITY (ABMS) CODE TABLE

Code	Speciality	Code	Sub-Specialty	Code	Speciality	Code	Sub-Specialty
A&I	Allergy and Immunology	CL1	Clinical and Laboratory Immunology			FP	Forensic Pathology
		DL1	Diagnostic Laboratory Immunology			Hem	Hematology
Anes	Anesthesiology	CCM	Critical Care Medicine			IP	Immunopathology
		PM	Pain Management			MMB	Medical Microbiology
CRS	Colon and Rectal Surgery					NP	Neuropathology
D	Dermatology	CLDI	Clinical and Laboratory Dermatological Immunology			PdP	Pediatric Pathology
		DI	Dermatological Immunology			RIP	Radioisotopic Pathology
		DP	Dermatopathology				
EM	Emergency Medicine		MT Medical Toxicology	Ped	Pediatrics	AI	Allergy and Immunology
		PEM	Pediatric Emergency Medicine			AM	Adolescent Medicine
		SM	Sports Medicine			CCM	Pediatric Critical Care Medicine
FP	Family Practice	Ger	Geriatric Medicine			Cd	Pediatric Cardiology
		SM	Sports Medicine			CLI	Clinical and Laboratory Immunology
IM	Internal Medicine	AI	Allergy and Immunology			DLI	Diagnostic Laboratory Immunology
		AM	Adolescent Medicine			En	Pediatric Endocrinology
		CE	Cardiac Electrophysiology			Ge	Pediatric Gastroenterology
		CCEP	Clinical Cardiac Electrophysiology			HO	Pediatric Hematology-Oncology
		CCM	Critical Care Medicine			Inf	Pediatric Infectious Disease
		CLI	Clinical and Laboratory Immunology			MT	Medical Toxicology
		CV	Cardiovascular Disease			Ne	Pediatric Nephrology
		DLI	Diagnostic Laboratory Immunology			NP	Neonatal-Perinatal Medicine
		EDM	Endocrinology, Diabetes and Metabolism			PEM	Pediatric Emergency Medicine
		En	Endocrinology			Pul	Pediatric Pulmonology
		Ge	Gastroenterology			Rhu	Pediatric Rheumatology
		Ger	Geriatric Medicine			SM	Sports Medicine
		Hem	Hematology				
		Inf	Infectious Disease	PMR	Physical Medicine and Rehabilitation		
		Nep	Nephrology	PS	Plastic Surgery	HS	Hand Surgery
		Onc	Medical Oncology	PrM AM	Aerospace Medicine	MT	Medical Toxicology
		Pul	Pulmonary Disease	PrM GPM	General Preventive Medicine	UM	Undersea Medicine
		Rhu	Rheumatology	PrM OM	Occupational Medicine		
		SM	Sports Medicine	PrM PH	Public Health		
MGCBGn	Clinical Biochemical Genetics			PrMPHGPM	Public Health and General Preventive Medicine		
MGCBMG	Clinical Biochemical Molecular Genetics			ChiN	Neurology with Special Qualifications in Child Neurology	AdP	Addiction Psychiatry
MGCCyTG	Clinical Cytogenetics					ChAP	Child and Adolescent Psychiatry
MGCCGen	Clinical Genetics (M.D.)			N	Neurology	ChiN	Child Neurology
MGCMGn	Clinical Molecular Genetics			Psyc	Psychiatry	C/Nph	Clinical Neurophysiology
MGPhdMG	Medical Genetics					FPsy	Forensic Psychiatry
NS	Neurological Surgery (NS-F indicates foreign certificate)					Ger	Geriatric Psychiatry
NuM	Nuclear Medicine			Rad DR	Diagnostic Radiology	NR	Nuclear Radiology
ObG	Obstetrics and Gynecology	CCM	Critical Care Medicine	Rad DRnt	Diagnostic Roentgenology	PR	Pediatric Radiology
		GO	Gynecologic Oncology	Rad NM	Nuclear Medicine	VIR	Vascular and Interventional Radiology
		MF	Maternal and Fetal Medicine	Rad R	Radiology		
		RE	Reproductive Endocrinology	Rad Rnt	Roentgenology		
Oph	Ophthalmology			Rad RO	Radiation Oncology		
OrS	Orthopedic Surgery	HS	Hand Surgery	Rad RT	Radium Therapy		
OMT	Osteopathic Manipulative Therapy			Rad TR	Therapeutic Radiology		
Oto	Otolaryngology			Rad DRMNIP	Diagnostic Radiology and Medical Nuclear Physics		
Path AP/CP	Anatomic and Clinical Pathology	BB	Blood Banking	Rad DRP	Diagnostic Radiological Physics		
Path AP	Anatomic Pathology	BBTM	Blood Banking Transfusion Medicine	Rad MNP	Medical Nuclear Physics		
Path CP	Clinical Pathology	ChemP	Chemical Pathology	Rad RP	Radiological Physics		
		CytoP	Cytopathology	Rad RRP	Roentgen Ray Physics		
		DP	Dermatopathology	Rad TDRP	Therapeutic and Diagnostic Radiological Physics		
				Rad TRNP	Therapeutic Radiology and Nuclear Medicine Physics		
				Rad TRP	Therapeutic Radiological Physics		
				Rad XRP	X-Ray and Radium Physics		
				S	Surgery	GVS	General Vascular Surgery
						HS	Hand Surgery
						PdS	Pediatric Surgery
						SCC	Surgical Critical Care
				TS	Thoracic Surgery		
				U	Urology		

This list was taken from the ABMS Directory of Board Certified Medical Specialists.

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Board Application."
- ☐ I have completed the Rhode Island Board application as instructed (pages 6-12).
- ☐ I have completed Section 20, "**Affidavit of Applicant**" and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 21, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** made payable (in U.S. funds only) to the General Treasurer, State of Rhode Island in the amount of \$437.50 (or \$537.50 with CSR application) and attached the payment as instructed.
- ☐ I have arranged my Board Application materials in following order:
 - 1. Fee (attached as instructed).
 - 2. Board Application (cover page, and pages 6-12)
 - 3. Supporting documentation as required. **[Note: Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.**
 - 4. RI Uniform Controlled Substances Registration (CSR) (page 19) (If Applicable).
- ☐ I have mailed the above application materials directly to the Licensing Office, Department of Health.

Required Forms / Letters

- ☐ I have completed and mailed the following forms as instructed:
 - 1. Reciprocity Release Form(s) (Licensure Verification)
 - 2. Practitioner Request for Information Disclosure (National Practitioner Data Bank)
 - 3. **Four (4)** Reference Forms

FCVS Application

- ☐ I have completed the FCVS application, and submitted all required forms, documents, and fee directly to FCVS.

Note: In order to dispense, prescribe, store, or order controlled substances, you must obtain a **Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration**.

The Rhode Island CSR Application is available on page 19. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: ☐
DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/



Substitute forms are not acceptable - This form may be duplicated as needed .
Rhode Island Board of Medical Licensure and Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

RECIPROCITY RELEASE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name

Signature

Date

Previous Names Used

Social Security Number

Date of Birth

License Number

Date Issued

THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD

Basis for Issuing License:

☐ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ FLEX _____ (State Sponsor) ☐ State Exam _____ (State)

If a combination of exams were taken, please list the specific combination: _____

License Status:

☐ Active ☐ Inactive ☐ Lapsed

Original Date Issued:

Expiration Date:

Questions:

1. Has this physician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature

Date

Type or Print Name

Title

Full Name of Licensing Board

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Substitute forms are not acceptable - This form may be duplicated as needed .
Rhode Island Board of Medical Licensure and Discipline

Room 205, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

REFERENCE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form to be completed as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Applicant Should Complete this Section Only:

Print/Type Full Name

Signature

Date

Social Security Number

Date of Birth

EVALUATION

Based upon demonstrated performance and composite of evaluations by supervisors on file.

		Superior	Good	Fair	Poor	No Info.
Basic Clinical Knowledge						
Professional Judgement						
Clinical Competence and Skill						
Reliability/Sense of Responsibility						
Patient Management						
Ethical Conduct						
Physician-Patient Relationship						
Ability to Work with Other Hospital Staff						
Appearance						
Medical Recordkeeping						
Ability to Communicate Verbally						
	Overall Rating:					

Recommendation:

- ☐ Recommended Highly without Reservation ☐ Recommended as Qualified and Competent ☐ Recommended with Reservation
☐ No Comment ☐ Not Recommended

Additional Comment (use reverse side if necessary):

You must affix your institution's official seal or have your signature notarized.

Printed Name of Reference

Signature

Title

Date

Relationship to Applicant

Please Affix
Hospital or
Notarial Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). I understand that this application **MUST** be submitted along with my Board Application. I also understand that there is an additional \$100.00 fee for this Registration and that the check or money order for **\$537.50 (NON-REFUNDABLE Board Application fee (\$437.50) PLUS CSR Application fee (\$100.00))** must be made out to the "RI General Treasurer".

Print/Type Full Name

Business Name

Signature

Business Address

Business Telephone

Date

Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm
	Drug Schedule (Check all that apply) <input type="checkbox"/> Schedule II <input type="checkbox"/> Schedule III <input type="checkbox"/> Schedule IV <input type="checkbox"/> Schedule V
A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.	A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*
The CSR is renewed at the same time that the professional license is renewed.	All Applicants MUST answer the following: A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
NOTE: Read Important Information on the bottom of this application.	If you answered "Yes" to question "A" or "B" attach an explanation to this form.
Important Information Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes " VOID ". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol. Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state. A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/ *You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174. NOTE: - Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription. - Prescriptions in schedules III, IV and V cannot be written for more than one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid. - Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.	

State of Rhode Island and Providence Plantations



DEPARTMENT OF HEALTH

Office of the Director

Cannon Building

3 Capitol Hill

Providence, RI 02908-5097

Mandatory Addendum to License Application

Verification of Social Security Number/Federal Employer Identification
Number and affidavit concerning taxpayer status

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature

Date

Social Security Number (SSN) or Federal
Employer Identification Number (FEIN)

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

This form MUST be completed, signed and attached to your license application in order for us to process your application.